Quarterly Doses Administered Report

For **Private / Public Provider** use

VFC PIN

2. Clinic Name		Phone #
Name of Person Submitting Form		Quarter / Year
3. I certify under penalty of law that the below information is true.	Signature	Date

Instructions for Completing the Quarterly Doses Administered Report

Complete and submit this form to the Utah VFC Program within 15 days following the end of each quarter.

1st Quarter:	*January, February, March*	Due **April 15th**
2nd Quarter:	*April, May, June*	Due **July 15th**
3rd Quarter:	*July, August, September*	Due **October 15th**
4th Quarter:	*October, November, December*	Due **January 15th**

1. Enter VFC Pin. (Verify if unsure of correct number.)
2. Print the clinc name, phone number, quarter and year of this report, and name of the person completing this form.
3. Read the attestation statement, sign and date. (Forms will not be accepted without signature.)
4. On the Total Number of Patients Vaccinated table, enter the number of VFC eligible children who received vaccines, by age and eligibility categories. **Total** each row and column.
5. Page two (reverse side), print clinic name and VFC Pin in top boxes. (When faxed, pages are separated.)
6. On the Total Number of VFC Doses Administered table, enter the number of doses administered to VFC eligible children, by age and vaccine type. **Total** each row and column.
7. On the Total Number of Underinsured Doses Administered table, enter the number of doses administered to underinsured children, by age and vaccine type. **Total** each row and column.
8. On the Total Number of CHIP Doses Administered table, enter the number of doses administered to CHIP enrolled children, by age and vaccine type. **Total** each row and column.

Use of Doses Administered Tally Sheet is Optional.
Please do NOT return Tally Sheets.

Mail or fax the Quarterly Doses Administered Report to:
Utah Department of Health
Immunization Program
PO Box 142001
Salt Lake City, UT 84114-2001
(801) 538-9450
FAX: (801) 538-9440

4. Total Number of **Patients Vaccinated**

Age	Vaccines for Children (VFC)			State Supplied		TOTAL
	Am. Indian/ Alaskan Nat.	Medicaid	Non-insured	Underinsured	CHIP	
<1						
1-6						
7-18						
>18						
Total						

→ Continue on back

5. Clinic Name	VFC Pin

6. Total Number of **VFC Doses** Administered

Age	DT	DTaP	DTaP/ Hep B/ IPV	DTaP/ Hib/ IPV	DTaP/ Hib	DTaP/ IPV	Flu	Hep A Ped	Hep B Ped	Hep B/ Hib	Hib	HPV	IPV	Meningo	MMR	MMRV	Pneumo	Rota	Td	Tdap	Var	**Total**
<1																						
1-6																						
7-18																						
>18																						
Total																						

6. Total Number of **Underinsured Doses** Administered (State Supplied)

Age	DT	DTaP	DTaP/ Hep B/ IPV	DTaP/ Hib/ IPV	DTaP/ Hib	DTaP/ IPV	Flu	Hep A Ped	Hep B Ped	Hep B/ Hib	Hib	HPV	IPV	Meningo	MMR	MMRV	Pneumo	Rota	Td	Tdap	Var	**Total**
<1																						
1-6																						
7-18																						
>18																						
Total																						

6. Total Number of **CHIP Doses** Administered (State Supplied)

Age	DT	DTaP	DTaP/ Hep B/ IPV	DTaP/ Hib/ IPV	DTaP/ Hib	DTaP/ IPV	Flu	Hep A Ped	Hep B Ped	Hep B/ Hib	Hib	HPV	IPV	Meningo	MMR	MMRV	Pneumo	Rota	Td	Tdap	Var	**Total**
<1																						
1-6																						
7-18																						
>18																						
Total																						